

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028639

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4291 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 14 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY WYANDOTTE	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 12 hrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LAKESIDE HOSPITAL		d. STREET ADDRESS (If outside, give location) 120 So. 15 St.	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHRYN SEIFERT		4. DATE OF DEATH Month JULY Day 31, Year 1963	
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1897
9. AGE (last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired clerical		10b. KIND OF BUSINESS OR INDUSTRY R.L. Polk Co.	
11. BIRTHPLACE (City and state or country) Lehigh, Kansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Peter Dirkson		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Karl Seifert		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Karl Seifert 120 So. 15 St.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial failure - DUE TO (b) toxemia + hypoxia - DUE TO (c) strangulated ventral hernia - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus - arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr 72 hrs 72 hrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION COUNTY STATE		21. I attended the deceased from 7/26/63 to 7/30/63 and last saw her alive on 7/30/63 Death occurred at 11:33 PM on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) C. J. Milazzo DO		22b. ADDRESS 1511 Euclid Ave KCMO	
22c. DATE SIGNED 7/31/63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 8-2-1963		23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	
23d. LOCATION (City, town, or county) Kansas City, Missouri		24. FUNERAL DIRECTOR Muehlebach 6800 Troost	
25. DATE RECD. BY LOCAL REG. 7-31-63		26. REGISTRAR'S SIGNATURE Keith Long	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

Dr. Renshaw
Laboure
Rudgerswood Clinic
12101 E. Hubbard Hwy
Jenkyns, Mo -

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed P. E. Nichols

Licensed Embalmer No. 4997

P. O. Address K.P. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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